

McLeod Health

Place Sticker Here

Ceftriaxone (Rocephin) Treatment Plan

Patient Name: _____ DOB: _____

Height (cm): _____ Weight (kg): _____ Allergies: _____

Diagnosis (select one ICD-10 code):

- L08.9 Local infection of the skin and subcutaneous tissue, unspecified R78.81 Bacteremia
- M86.10 Other acute osteomyelitis, unspecified site M86.60 Other chronic osteomyelitis, unspecified site
- Other ICD 10 Code: _____ Diagnosis Description: _____

Drug Orders: The physician will select appropriate dosing based on indication

- Heparin and NS or D5W flushes as needed to maintain line
- Related items and/or supplies needed to administer medication and complete prescribed therapy
- Ceftriaxone (Rocephin) (J0696) per 100 mL NS IV to infuse over 30 minutes
- Dose: Ceftriaxone 1 gram Q24H
 Ceftriaxone 2 grams Q24H
 Other dose: _____
- Duration: 6 weeks (end date: _____)
 Other duration: _____ (end date: _____)

Lab Orders:

- Complete blood count (CBC) with differential weekly with reported results
- Basic metabolic panel (BMP) weekly with reported results
- C-reactive protein (CRP) weekly with reported results
- Other: _____

Standing Orders:

- Infusion Reaction Protocol (CPOE-1396) will be activated if any hypersensitivity reaction occurs, including anaphylaxis. Infusion will be stopped and physician notified.

Physician Signature: _____ Date: _____

Physician Name: _____ Phone: _____

Insurance/Authorization Information:

Insurance Type: _____

Insurance Authorization Reference Number: _____

Date Obtained: _____ Authorization Valid Until: _____

Additional Notes: _____

Fax completed Treatment Plan with authorization information to McLeod Infusion Services at the number below or call with any questions.

Cheraw: 843-320-3469 (Fax)

843-320-5557 (Phone)